



ADVOCATE PSYCHOTHERAPY SERVICES

SERVING ALL OF CENTRAL WISCONSIN — TO HELP YOU FIND WHAT'S MISSING

Toll Free: 800-681-2374

Mailing Address: PO Box 959, Stevens Point, WI 54481

Fax: 715-952-4995

Email: office@advocatepsychotherapyservices.com

Website: www.advocatepsychotherapyservices.com

CREDIT CARD AUTHORIZATION FORM

If you are using your insurance benefits, Advocate Psychotherapy Services, LLC (“APS”) offers this form as part of an **OPTIONAL** request to get your credit card information in order to charge you the fee of your **FIRST** session on **THE SAME DAY** that your service is provided. The card information you can use includes a variety of HSA, Flex, Rewards cards, or any others that have a Visa, MasterCard, AMEX, or Discover logo.

Once your card information is on file, whenever we receive a Remittance Advice statement (i.e. client responsibility information) from your insurance company we will then charge your card accordingly. **However, the fee that you paid at your first session will act as a credit on your account to use first.** Any additional money due for deductibles, copays, or coinsurance amounts will be charged as they are processed by insurance. **If it is found that no client portion has been assigned to you after several sessions (APS has confirmed that insurance is covering everything), you can request a refund of what you paid at your first session.**

It is your responsibility to check on your own coverage and eligibility as APS does not check that for you ahead of time. In addition, many insurance coverage options now have changed to High Deductible Plans. The end result of these topics means that many sessions can be out to insurance at the same time resulting in a large balance due when finally processed. This can be a burden to the client as well as lead to significant balances for APS to carry as an entity. Paying ahead of time helps makes the financial aspect of counseling less of an issue.

By paying via credit card, you acknowledge that this credit card information will be automatically kept on file via PCI-compliant encrypted code with our merchant/credit card processor: **BluePay (www.bluepay.com)**. You further agree and understand that if insurance does not pay the contracted rate for services, that any remaining balance due is your responsibility and therefore will be charged to this credit card. After a charge is run, APS will send a printed receipt via regular mail reflecting the charge applied to your card.

*By signing this form, I authorize APS to keep my credit card on file with its merchant system (“BluePay”) and to charge my credit card an amount not to exceed **\$250 per charge** for all balances due including any No Show Fees as described in the Informed Consent. This authorization expires 12 months from the date listed.*

Signature: _____ Date: _____

Client Name: _____

Credit Card Number: _____ CVV Code: _____

Name on Card: _____ Expiration Date: _____

Billing Address:

Street: _____

City: _____ State: _____ Zip Code: _____